Claims Clues

A Monthly Publication of the AHCCCS Claims Department September, 2000

Providers Should Keep Remit with Credit Memo

Providers should keep a copy of the AHCCCS Fee-For-Service Remittance Advice whenever a credit memo is generated because the remittance explains all of the patient information and reasons why the claims were voided or adjusted.

A claim that has been voided or adjusted may or may not generate a credit memo for that week's cycle, depending on the amount of paid claims.

If the paid claims amount is more than the amount of the credit, the AHCCCS system will recoup only the amount of the credit and generate a payment for the difference. If the paid claims amount is less than the amount of the credit, the system will apply that amount against the credit. In this case, an outstanding credit balance will show up on the Financial Summary (Page 2) of the provider's remittance.

If the voided or adjusted amount is large, it may require more than one recoupment. A provider may have an outstanding credit balance for a week or more.

Patient information on the voided/adjusted claims will not show up on future remittance advices. Providers should pay special attention to remittances that show credit memos.

Providers may obtain copies of previous remittance advices, but there is a charge of $2.00 per page.

Providers who have questions about adjusted or voided claims should contact Claims Customer Service:

(602) 417-7670 (Phoenix area)

(800) 794-6862 (In state)

(800) 523-0231 (Out of state) ❒

Enter AHCCCS ID on Electronic Medicare Claims

When transmitting electronic claims to Medicare, providers should enter their AHCCCS ID number in the Medicaid ID number field.

The Medicaid ID field also is on the crossover tape layout that AHCCCS uses to process Medicare crossover claims. Entering the AHCCCS ID in the Medicaid ID field on electronic submissions to Medicare will expedite the crossover process and reduce the likelihood of misdirected reimbursement checks.

Providers who are not sure where the Medicaid ID field is on their electronic transmissions to Medicare should contact their Medicare carrier.

It is important that each provider's record with AHCCCS contain the individual provider's Medicare ID number.

Providers should complete the form that is attached to this issue of *Claims Clues* and submit it as directed. Providers should enter their *individual* Medicare ID number, *not* a group ID number.

Under the crossover process, when a provider submits a claim to Medicare for an AHCCCS-eligible recipient, the claim is automatically crossed over to AHCCCS for payment of coinsurance and deductible when Medicare issues reimbursement. Providers no longer must submit claims to AHCCCS for payment of coinsurance and deductible on paid Medicare claims for AHCCCS recipients.

This same process also applies to claims submitted to AHCCCS for QMB only recipients. QMB only recipients are eligible for reimbursement of coinsurance and deductible for Medicare-covered services. ❒

Admit Type Change Requires Written Request

In order to change the admit type on a UB-92 claim, providers must either resubmit the claim or submit a Claim Correction Request form.

The Claims Customer Service Unit no longer will accept a change in admit type over the telephone. Providers may make the following changes to claims by calling the Claims Customer Service:

- Zero fill Medicare and TPL information
- Enter Medicare amounts if provider faxes EOMB
- Change, add, or delete a procedure modifier
- Change, add, or delete diagnosis and revenue codes (This may cause the claim to re-edit for coverage, age and gender limits, etc.)
- Change or delete procedure and NDC codes (This may cause the claim to re-edit for coverage, age and gender limits, etc.)
- Change number of units
- Change or add bill type, admit date/ source, coinsurance days, and dates of service (UB-92)
- Change dates of service (HCFA 1500)
- Change or add discharge hour
- Change or add patient status
- Change, add, or delete occurrence codes and dates
- Change, add, or delete condition codes
- Change or add place of service codes

These changes also can be made by submitting a Claim Correction Request form. The forms are available from Customer Service.

To contact Claims Customer Service, call:

(602) 417-7670 (Phoenix area)
(800) 794-6862 (In state)
(800) 523-0231 (Out of state) ❐

Claims Must Include Provider ID, Locator Code

An AHCCCS provider ID number and correct two-digit locator code must be entered on all fee-for-service claims submitted to the AHCCCS Administration.

AHCCCS Claims Department staff no longer will attempt to determine the correct provider ID number if a claim is submitted without one. Claims submitted without a provider ID number will be denied, and a letter explaining the reason for the denial will be sent to the address listed on the claim form.

If a claim is submitted with a provider ID number but no locator code, the claim may be denied or payment may be misdirected.

Please see the August, 1999 issue of *Claims Clues* for a complete explanation of provider addresses and locator codes ❐

Hospitals Must Split Dialysis, Other O/P Services

Effective with claims for dates of service on and after July 1, 2000, fee-for-service claims from hospitals with Medicare-certified outpatient dialysis facilities must be split between dialysis services and other outpatient services.

Hospitals must submit claims for outpatient dialysis services on the UB-92 claim form using the 72X bill type. Other outpatient services, (e.g., clinic, X-ray, etc.) must be billed on a separate UB-92 using the 13X bill type.

Hospitals previously were allowed to bill the AHCCCS Administration for dialysis services and other outpatient services on the same UB-92 claim form.

AHCCCS will continue to pay hospital outpatient dialysis and non-dialysis claims using the hospital-specific outpatient cost-to-charge ratio.

The change in billing requirements was prompted by Medicare's implementation of its Prospective Payment System (PPS) for outpatient services. ❐

Need Help with a Claim?

Contact Claims Customer Service
(602) 417-7670 (Phoenix area)
(800) 794-6862 (In state)
(800) 523-0231 (Out of state)

Hours: 7:00 a.m. – Noon
12:30 – 4:00 p.m.

Medicare ID Number

In order to correctly process your Medicare crossover claims and reduce the likelihood of misdirected reimbursement checks, the following information must be on file with AHCCCS:

- ✓ Your Medicare Provider ID Number (NOTE: Please provide your *individual* Medicare Provider ID Number, *not* a group ID number.
- ✓ Medicare coverage (Part A and/or Part B)
- ✓ The name of your Part A Intermediary and/or your Part B Carrier (e.g., BC/BS of AZ, BC/BS of ND, BC/BS of TX)
- ✓ Begin date and end date (if applicable).

If you have any questions about submitting this information, please contact the Provider Registration Unit at (602) 417-7670 (Option 5). If you have questions related to how your Medicare claim is processed, contact the Claims Customer Service Unit at (602) 417-7670 (Option 4).

Medicare Provider ID Number	**Medicare Coverage (Part A and/or B)**	**Name of Part A Intermediary (if applicable)**	**Name of Part B Carrier (if applicable)**	**Begin Date (MM/DD/YYYY)**	**End Date (MM/DD/YYYY)**

Provider Signature

AHCCCS Provider ID Number

Provider Name (Please type or print only)

Date

Mail this form to: AHCCCS Provider Registration Unit
MD 8100
701 East Jefferson Street
Phoenix, AZ 85034

or

Fax this form to: AHCCCS Provider Registration Unit
(602) 256-1474